Dear Transgender Benefits Collaborative Committee,

We appreciate the work the Department of Health Care Policy and Financing has done to engage stakeholders to codify and streamline coverage for transgender clients on Medicaid. Below is the feedback from One Colorado on the proposed benefit related to surgery for transgender Coloradans on Medicaid.

Medicaid Clients 20 Years and Younger

- Making coverage for GnRH analogs available concurrently with mental health evaluation is the best practice so the client isn't waiting 6 months.
- We recommend the threshold for initiating puberty delay treatment to be definitively set at Tanner Stage 2, not "Stage 2-3" (see, e.g., http://press.endocrine.org/doi/full/10.1210/jc.2009-0345).
- **Question:** What will the protocol be surgeries for individuals under 20 years? In some cases, individuals under the age of 20 will not have been able to access puberty delay treatment and surgery will be necessary to effectively treat gender dysphoria.

Medicaid Clients Age 21 and Older:

- We recommend there be no prerequisite for surgery that an individual has previously undergone 12 months of continuous cross-sex hormone therapy. For some individuals, cross-sex hormone therapy is entirely contraindicated by, e.g, cardiovascular- or cancer-related risk factors, and some individuals need surgery but not hormone therapy for the effective treatment of gender dysphoria.
- The requirement that the surgery letters "outline any other medical or behavioral health conditions for which the provider is treating the client" is unethical and a violation of the patient's privacy. We recommend these letters outline any conditions that are *potentially* related to or relevant to the patient's course of treatment related to gender dysphoria, but other medical or behavioral health records of treatment should not be required as part of the process of gender transition.
- The restriction of augmentation mammoplasty to "clients who do not develop breasts after cross-sex hormone therapy" is a subjective assessment that, most significantly, does not take into account the complex social circumstances of living safely as a transgender woman and also inappropriately sidelines the judgment of the treating physician regarding the effective treatment of gender dysphoria.
- The list of covered services for transgender men should include nipple grafts to effectively treat gender dysphoria.
- Per the standard set by the NYS Medicaid Program (which excluded transition-related coverage entirely for many years until 2015; see attached NYS guidance for an example by searching for "gender" and scroll down), the list of "non-covered services" should be amended to state: ***"Payment will not be made for any procedures that are performed solely for the purpose of improving an***

individual's appearance. The following procedures may not be covered, <u>unless justification of medical necessity is provided and prior authorization is received</u>:

- *Abdominoplasty;*
- *Blepharoplasty;*
- *Calf, cheek, chin, or nose implants;*
- *Hair transplantation;*
- *Hair removal;*
- *Laryngoplasty;*
- *Liposuction;*
- *Thyroid chrondoplasty;*
- *Other procedures conducted for the purpose of Facial or Body Feminization or Masculinization; or*
- *Reversal of any surgery, procedure, or service listed in the Covered Gender Confirmation Surgeries section of this Benefit Coverage Standard*

- This language ensures that these services could be covered if medically necessary to treat gender dysphoria

Again, thank you for engaging stakeholders in this very thoughtful and thorough process for transgender clients on Medicaid. Please reach out with any additional questions.

Sincerely,

Daniel Ramos
Deputy Executive Director
One Colorado